Basic Health™
Washington Basic Health Plan

FAMILY CHANGES FORM

Instructions begin on page 6.

THIS PAGE MUST BE COMPLETED AND RETURNED

SECTION ONE

APPLICANT Giving your Social Security number is voluntary, but it speeds handling your application. If you do not provide a Social Security number, an I.D. number will be assigned to you. If you are applying for Basic Health coverage through your employer, you must provide your Social Security number.

Social Security number – –	Last name	First name	Middle initial

House number / Street address / Apt./Unit number	City	County	State	ZIP Code
Mailing address (if different from street address)	City	County	State	ZIP Code

Home phone number ( )	Day phone number ( )	Are you a U.S. citizen? ❑ Yes ❑ No	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for yourself? ❑ Yes ❑ No Applying for reduced premium? ❑ Yes ❑ No	Are you: ❑ Single ❑ Legally married ❑ Legally separated ❑ Divorced If married, separated, or divorced, give effective date: / /	Do you want coverage for someone who is currently pregnant? ❑ Yes ❑ No If yes, include doctor's verification of pregnancy. List the full name and due date of the person who is pregnant: Name Due date / / Doctor's phone number ( )	Do you need an interpreter? ❑ Yes ❑ No If so, we will talk with you through an interpreter. What language do you speak?

Are you disabled and over age 19? ❑ Yes ❑ No If yes, are you receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	Eligible for Medicare? ❑ Yes ❑ No	Are you receiving medical assistance from DSHS? ❑ Yes ❑ No	Are you applying for coverage for a child with an urgent medical need? ❑ Yes ❑ No Name	Are you applying for: ❑ Individual coverage ❑ Group coverage (employer, financial sponsor, or home care agency)

SPOUSE If you are legally married, list your spouse even if he/she is not applying for coverage. If your spouse does not live in your household, or if you and your partner are living in the same household but are not married, your spouse or partner needs to fill out a separate application to apply for coverage.

Last name	First name	Middle initial	Social Security number – –	Birth date / /	Sex ❑ Male ❑ Female

Applying for coverage for this person? ❑ Yes ❑ No	U.S. citizen? ❑ Yes ❑ No	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	Eligible for Medicare? ❑ Yes ❑ No	Receiving medical assistance from DSHS? ❑ Yes ❑ No

DEPENDENTS If you are applying for Basic Health Plus coverage for your child, you must provide the child's Social Security number. If you have more than two dependents, please provide the information on a separate sheet of paper.

❑ Check here if you need help with a child's unpaid medical bills from the last three months. (Be sure to include income documentation for those months.)

❑ Check here if you want Basic Health coverage for children while Basic Health *Plus* eligibility is being determined. Please note: You will be charged premiums for children enrolled in Basic Health.

1. Last name	First name	Middle initial	Social Security number – –	Birth date / /

Applying for coverage for this person? ❑ Yes ❑ No	Full-time student (age 19-23)? ❑ Yes ❑ No School Phone ( )	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	U.S. citizen? ❑ Yes ❑ No	Sex ❑ Male ❑ Female

Receiving medical assistance from DSHS? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No	Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)	Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No	Relationship to applicant

2. Last name	First name	Middle initial	Social Security number – –	Birth date / /

Applying for coverage for this person? ❑ Yes ❑ No	Full-time student (age 19-23)? ❑ Yes ❑ No School Phone ( )	Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability? ❑ Yes ❑ No Entitlement date / /	U.S. citizen? ❑ Yes ❑ No	Sex ❑ Male ❑ Female

Receiving medical assistance from DSHS? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No	Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)	Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No	Relationship to applicant

INFORMATION ON OTHER HEALTH COVERAGE Please list any family members who currently have other health insurance (such as Premera Blue Cross, Group Health Cooperative, or an employer-sponsored plan) or are covered under a health program (such as Tri-Care or Medicaid). Be sure to include yourself and/or family members who are not applying for Basic Health coverage, if applicable. Please list subscriber's name for this coverage first.

Last name First name Middle initial	Health insurance company or health plan	Phone number of insurance company or health program*	Policy or group number*	Policy end date*
1. (Subscriber)		( )		/ /
2.		( )		/ /
3.		( )		/ /

* Complete these columns only if applying for Basic Health Plus or the Maternity Benefits Program.

SECTION TWO

IF APPLYING FOR BASIC HEALTH PLUS COVERAGE If the other biological parent of your child(ren) is not legally married to you, but is living in your home, please provide us with the information below. This allows the parent to be counted in the household size and the parent's income to be considered as part of the household income. Provide proof of this parent's income for the most recent 30 days or complete calendar month.

Last name	First name	Middle initial	Birth date / /	Social Security number – –

Please list the full name(s) of this parent's child(ren), as listed on this application.	Daytime phone number ( )

SECTION THREE

GROUP COVERAGE Complete *only* if your premium is paid in full or in part by your employer, home care agency, or financial sponsor. Return this completed application directly to your employer, home care agency, or financial sponsor.

Employer/organization	Group I.D. number (if known)	I want to waive group coverage for myself, my spouse, and all dependent children. ❑ Yes ❑ No

Mailing address	City	State	ZIP Code +4	Phone number ( )

SECTION FOUR

HEALTH PLAN SELECTION (This section should be completed only by dependents transferring to their own account.) A list of the health plans available to you, along with their monthly premiums, is in the *"You-Pay" Tables*. All plans provide the same basic benefits, but premiums vary and the providers available to you differ from plan to plan.

I am aware that I have the right to a choice of health plans for Basic Health coverage as listed in the *"You-Pay" Tables* provided to me with this application. I choose to receive Basic Health or Basic Health Plus coverage for myself and my family members through the following health plan:

_____

THIS PAGE MUST BE COMPLETED AND RETURNED

SECTION FIVE

MONTHLY INCOME WORKSHEET

For information on how to complete this Monthly Income Worksheet, follow the "Line-by-Line Instructions for Monthly Income Worksheet" located on pages 8 and 9. If you have rental or self-employment income, you must also fill out the Self-Employment/Rental Income Worksheet on the other side of this form.

- List gross income for your household for the most recent 30 days or complete calendar month (before taxes are deducted). **Attach proof of all income** as described in the "Line-by-Line Instructions for Monthly Income Worksheet," including a signed copy of your most recent federal income tax return. Whether you filed by mail or electronically, you must sign the IRS Form 1040 (your tax preparer's signature is not sufficient). If you were not required to file or do not have a copy of your tax return for the most recent year, you must send a transcript of your account, which you can request directly from the IRS by calling **1-800-829-1040**.
- In most cases, your eligibility for a reduced premium depends only on your income during the most recent 30 days or complete calendar month. If your income changes enough from month to month to change your premium, you may want to check the box below and request that your last three months' income be averaged. If your income is averaged, your premium will not change for six months unless all Basic Health premiums change or your individual circumstances change (for example, you lose your job or your family size changes).

❑ Check here if you want your monthly Basic Health premium averaged based on the most recent three consecutive months' income, and be sure to attach proof.

Income source *(rounded to the nearest dollar)*	**A** Self	**B** Spouse	**C** Child	Name of dependent child
1 Wages, commissions, tips, work study	$	$	$	
2 Self-employment profit or loss (from line 31 of the Self-Employment/Rental Income Worksheet)	$	$	$	
3 Unemployment compensation, strike benefits	$	$	$	
4 Social Security benefits	$	$	$	
5 Supplemental Security Income (SSI)	$	$	$	
6 Retirement, pension, IRA distributions	$	$	$	
7 Child support, family support, alimony	$	$	$	
8 Insurance benefits	$	$	$	
9 Income from interest, dividends, trust, annuity	$	$	$	
10 Veteran's benefits, military allotment	$	$	$	
11 Labor & Industries benefits	$	$	$	
12 Public assistance (DSHS grants)	$	$	$	
13 Other income (explain):	$	$	$	
14 Subtotals	$	$	$	

15	Total	$
16	Subtract work-related child care expenses (attach proof)	$
17	Total gross monthly income	$

If you are reporting no income, briefly state below how you supported yourself:

Printed name	Subscriber I.D. number - -
Signature (must be signed)	Date / /

Complete other side if reporting income from self-employment or rental property.

THIS PAGE MUST BE COMPLETED AND RETURNED ONLY IF YOU ARE SELF-EMPLOYED OR HAVE RENTAL INCOME

SELF-EMPLOYMENT/RENTAL INCOME WORKSHEET

For help in completing this form, follow the "Line-by-Line Instructions for Self-Employment/Rental Income Worksheet," beginning on page 10.

YOU MUST include a signed copy of your most recent income tax form (IRS Form 1040), including Schedules C, E, and F, as appropriate. If you were not required to file a tax return for the most recent tax year, see "General Instructions for Self-Employment/Rental Income Worksheet" on page 10. If reporting fewer than 12 months of income (see "General Instructions for Self-Employment/Rental Income Worksheet"), please indicate the actual number of months here:_____.

1 Check one: ❑ Self-employment income ❑ Rental income (use separate form for each business/type)

2 Business name		3 UBI number	
4 Business address	City	State	ZIP Code +4
5 Type of business		6 Taxpayer I.D. or Social Security number	

BUSINESS EXPENSE WORKSHEET Reporting income and expenses for: / – / (mo/yr – mo/yr)	**I** Twelve-month total	**II** Average monthly expenses	**III** Average monthly income
INCOME			**A**
7 Gross receipts, sales, or rental income	$		$
EXPENSES			
8 Merchandise and materials *(cost of goods sold)*	$	$	
9 Gross wages paid to employees *(do not include yourself, spouse, or partner[s])*	$	$	
10 Employer's payroll-related taxes *(OASI, L&I, UI, etc.)*	$	$	
11 Advertising/other promotional expenses	$	$	
12 Car and truck expenses	$	$	
13 Commissions/management fees	$	$	
14 Depreciation	$	$	
15 Insurance	$	$	
16 Interest – mortgage	$	$	
17 Interest – other	$	$	
18 Legal and professional services	$	$	
19 Rent or lease – vehicles, machinery, or equipment	$	$	
20 Rent or lease – other business property	$	$	
21 Repairs and maintenance	$	$	
22 Supplies *(office supplies, postage, etc.)*	$	$	
23 Taxes *(licenses and non-payroll)*	$	$	
24 Travel	$	$	
25 Meals and entertainment	$	$	
26 Utilities	$	$	
27 Other expenses *(must include description)*	$	$	
28 Total average monthly expenses *Add column II.*		$ **B**	
29 Average monthly self-employment profit (or loss) *Subtract B from A, and record in C.*			$ **C**
30 Your share of profit (or loss) Form of business: ❑ Sole proprietorship ❑ Partnership ❑ S-Corporation		Percentage of business you own	**D**
31 Your share of average monthly self-employment/rental net profit (or loss) *Multiply C by D.*			$
32 Printed name			Subscriber I.D. number – –
33 Signature			Date / /

SECTION SIX

AGREEMENT (MUST BE SIGNED) I understand that:

- I must report address changes and changes in my family, for example, the birth of a child, a child who is no longer a dependent, marriage, or divorce.
- I authorize any health plan or medical provider to furnish Basic Health any and all records pertaining to my medical history or the medical history of my children under age 18, and services or treatment given to me or my children under age 18, for purposes of confidential review or other activities related to my participation or the participation of my family in Basic Health/Medical Assistance programs.
- If I am applying for a reduced premium or for Medical Assistance,
  - The information submitted with this application is subject to verification by Basic Health and the Department of Social and Health Services (DSHS), through contact with other state or federal agencies.
  - I must provide proof of my income and report income changes to Basic Health/DSHS. My signature on this form authorizes Basic Health to verify my income with other state or federal income reporting agencies.
  - By asking for and receiving Medical Assistance benefits, my family and I assign to the state of Washington our rights to any third party payment for medical care of covered medical services while receiving medical benefits.
  - I understand that the information I am providing may be used to determine eligibility for Medicaid (Basic Health Plus) coverage for my children and Medical Assistance for maternity services.
- My signature below certifies that the information I am providing with this application is true and complete. I understand that anyone who submits false information may lose coverage, may be held financially responsible for any covered services obtained under Basic Health, and may face other penalties for prosecution and collection. A deposit of premium payment does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Signature of applicant	Signature of spouse	Date / /
Signature of all others over age 18 applying for coverage	Signature of all others over age 18 applying for coverage	

BE SURE TO:
- Enclose all required materials (including proof of income and Washington State residency).
- Have all family members over age 18 who are applying for coverage sign the "Agreement" above.

Mail this application and the required materials to Basic Health, P.O. Box 42683, Olympia, WA 98504-2683.

Basic Health™
Washington Basic Health Plan

Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

INSTRUCTIONS: FAMILY CHANGES FORM

Please complete the attached *Family Changes Form* to make changes to the family member covered on your account for either Basic Health coverage or family size.

Complete the attached application in the following situations:

- Marriage
- Newborn/newly adopted child
- Adding other dependents
- Transfer of student to separate account
- Divorce

Call Basic Health to request the necessary packet in these situations:

- Pregnancy
- To request Basic Health Plus coverage for any children currently enrolled in Basic Health
- To enroll a family member who has lost other coverage

If you have questions about the information or documentation needed, call Basic Health at **1-800-660-9840**.

The following information explains which portion(s) of this form you need to complete for your specific situation. Beginning on page 7 you will find detailed instructions for completing the different sections.

If you need additional forms, you may either call Basic Health to request them, or photocopy the attached form.

Make sure you have completed all required information, and that you and any family members over age 18 who are being added for coverage have signed the agreement.

Enrolling a new family member will change your monthly premium. The confirmation notice/personal eligibility statement you receive from Basic Health will indicate your new premium amount. There is no additional cost for children enrolled in Basic Health Plus, but your premium may increase if you are requesting regular Basic Health coverage.

Marriage:
To add coverage for a new spouse, your completed *Family Changes Form* must be received by Basic Health within 30 days of the date of your marriage. Otherwise, your spouse will be added for family size only, and cannot be added for coverage until the next Basic Health open enrollment period, which usually occurs in the fall of each year.

You must also follow the instructions under "When the Form is Completed" (on page 12) for submitting:

- Current income information, including IRS documentation (if you pay a reduced premium); and
- Proof of residency (if you have moved).

Adding a Newborn or Newly Adopted Child:
To add coverage for a newborn or newly adopted child, your completed *Family Changes Form* must be received by Basic Health within 60 days of the birth or placement for adoption. Otherwise, the child will be added to your account for family size only and cannot be added for coverage until the next Basic Health open enrollment period. If you enroll your newborn or newly adopted child the first of the month following his or her birth or placement for adoption, coverage will be effective from the date of birth or physical placement for adoption.

- You must submit current income documentation if you are applying for Basic Health Plus coverage for a newly adopted child.

Adding Other Dependents:
Only your legal dependents may be added to your Basic Health account. If you are applying for coverage for a child or disabled adult dependent who is not your biological child, adopted child, or stepchild, you must include a copy of the court order proving legal guardianship. Your application for coverage must be received within 30 days of the date the individual became your legal dependent or moved into your home.

- You must submit current income documentation if you are applying for Basic Health Plus coverage for this dependent.

Transfer of Student to Separate Account:
To apply for Basic Health when you are no longer eligible to be enrolled on your parents' account (turning age 19 and not a full-time student, or turning age 23), you must submit your completed application and all additional documentation. To retain continuous coverage through Basic Health, be sure to return this form with all required documentation and your first month's premium payment as early as possible. See the enclosed *"You-Pay" Tables* to determine your monthly premium. If your application is not received timely, you may have a break in coverage.

To obtain this document in an alternative format (such as Braille or audio),
call our Americans with Disabilities Act (ADA) Coordinator at (360) 923-2805.
TTY/TDD users (deaf, hard of hearing, or speech impaired), call (360) 923-2701 or toll-free 1-888-923-5622.

You must follow instructions under "When the Form is Completed" (on page 12) for submitting:
- Current income information, including IRS documentation (if you pay a reduced premium); and
- Proof of residency.

If you are under age 23 and a full-time student, please submit a copy of your school registration, or a note from the school indicating that you are a full-time student. If Basic Health does not receive confirmation of your full-time student status, you will be removed from your parents' account.

Divorce:
To take action on your account due to separation or divorce, your completed *Family Changes Form* must be received by Basic Health within 30 days of the date you reported the change to Basic Health. Your spouse has been sent an identical packet of information.

If there are children on your account, please submit a copy of the court order regarding their custody. Without a copy of a court order determining a parent's custody or obligation to provide for the child's health care coverage, the child will remain on the current subscriber's account. Children can be claimed as dependents on only one parent's account. If the children are covered under Basic Health Plus, their current eligibility may have to be redetermined.

If you have reconciled and are living in the same home, you must notify Basic Health, in writing, and we will stop the separation of your account.

You must follow the instructions under "When the Form is Completed" (on page 12) for submitting:
- Current income information, including IRS documentation (if you pay a reduced premium); and
- Proof of residency (if you have moved).

If a family member can still be claimed for family size on your account, but you wish to disenroll them from Basic Health coverage, please attach a letter requesting disenrollment when submitting this form to Basic Health.

Instructions for Section One:

- List each family member (yourself and all your dependents), including members who are currently covered by Basic Health and those who will not have Basic Health coverage. Include the name and phone number of the school if a dependent is a full-time college student, age 19 to 23.
- In the space marked "Social Security number," please enter your subscriber I.D. number, as it appears on your monthly invoice.
- If any family members are now eligible for free or purchased Medicare coverage, they are not eligible for Basic Health — however, they must be listed for family size.
- If any family members on this application are receiving Social Security Disability benefits, include the entitlement date.
- If you are applying for reduced-premium or Basic Health Plus coverage for a child who has an urgent medical need, or you need help with a child's unpaid medical bills *from the last three months*, indicate that in the spaces provided. You will be required to submit supporting income documentation for the three months when requesting back medical coverage. If you are self-employed, DSHS will require your most recent 30-day income, rather than the average income that Basic Health uses to determine eligibility and premium calculation. Basic Health will coordinate with the Department of Social and Health Services' Medical Assistance Administration to determine eligibility for other Medical Assistance programs.
- If you are applying for Basic Health coverage for a dependent who does not live with you, you must include proof of Washington State residency for that child as well. (A child attending school out of state, but otherwise still living in your home, is considered to be a Washington State resident.)

Information on Other Health Coverage:
- If you have other coverage, you need to provide the insurance company's phone number, your policy number, and your policy end date only if applying for Basic Health Plus or the Maternity Benefits Program. The policy or group number should be listed on the identification card you received from the other insurer. If you are unsure of it, or of the policy end date, you may verify this information by calling the insurer's customer service number (usually listed on the identification card, explanation of benefits statement, or premium statement).

Instructions for Section Two:

- You must complete this section if you are applying for Basic Health *Plus* coverage for anyone on this application. Individuals age 19 or older, or those attending college, are not eligible for Basic Health *Plus*.

Instructions for Section Three:

- Complete only if your premium will be paid in full or in part by your employer, home care agency, or financial sponsor.

Instructions for Section Four:

- You should complete this section only if you are a dependent transferring to your own Basic Health account. In other cases, you and your family will remain with the health plan that currently provides your Basic Health coverage unless you are moving to an area where it is not available.
- Read the *"You-Pay" Tables* to find out which health plans are available in your county and the cost of each; then read the "Plan Summaries" section in the *Consumer Guide* for information on a specific health plan. Call the health plan(s) you are considering to get a list of providers, and/or contact your provider to see if he or she contracts with the health plan. Be sure the health plan and/or your provider understands that you are applying for Basic Health.

Instructions for Section Five:

General Instructions for Monthly Income Worksheet

Fill out the Monthly Income Worksheet to report all gross family income, from all sources, before taxes. Gross family income includes all income received by the applicant/subscriber and any listed dependents, regardless of whether they are enrolled in the Washington Basic Health Plan. If you have self-employment or rental income, you must also complete the Self-Employment/Rental Income Worksheet (on the back of the Monthly Income Worksheet).

- For each line (and column), show all gross income received during the last 30 consecutive days or most recent calendar month. Please enter the actual dollar amount or "0" on each line, if not applicable.
- If you (or one of your dependents) have received several months' income during a single 30-day period (or calendar month), you may divide that income by the number of months for which the income was received. For example: In September, Bob applied for Social Security Disability Insurance (SSDI). In January of the following year, Bob received his first check from the Social Security Administration in the amount of $5,000. Bob became entitled to SSDI in September, but did not receive payment until January. The check Bob received in January covered his monthly entitlement from September through January (five months). Bob's gross monthly income from this source is $1,000 ($5,000 ÷ 5 months = $1,000 per month).
- If you have earned zero income ($0), you must include a signed, dated statement which documents that you had zero income during the last 30 consecutive days or most recent calendar month, and a brief description of how you supported yourself.
- If the "Line-by-Line Instructions" include directions to "**send**" specific income documentation, you must send copies of that information with your application in order for your application to be complete. If you have questions, call Basic Health at 1-800-826-2444 and speak with a customer service representative.
- All income documentation must show the date the income was received, the period for which the income was earned, and the recipient's name and/or Social Security number.
- If you **cannot** obtain the required income documentation, you must send a signed, dated statement which includes the name of the recipient, the payment dates, the income source, and the gross payment amount.
- Attach a **signed** copy of the applicant's most recent tax return filed with the Internal Revenue Service. This must be signed by the applicant, regardless of whether it was filed by mail or electronically (your tax preparer's signature is not sufficient). Include all applicable schedules.
- If you were not required to file a tax return or do not have a copy of your tax return for the most recent year, you must send a transcript of your account, which you can request directly from the IRS by calling 1-800-829-1040.
- Be sure to sign and date the completed form.

Line-by-Line Instructions for Monthly Income Worksheet

Line 1 **Wages, commissions, tips, work study**

Fill in the total dollar amount of any wages, commissions, tips, or work study income received. **Send** copies of pay stubs showing any wages, commissions, tips, or work study income received.

- ***Personal Care Workers*** **Send** the Social Service Payment System (SSPS) Service Invoice Voucher.
- ***Foster Parents*** Do *not* include reimbursement received for foster parenting.

Line 2 **Self-employment profit or loss**

If you have received any self-employment or rental income, complete the Self-Employment/Rental Income Worksheet. **Transfer** the amount from line 31 on the Self-Employment/Rental Income Worksheet to line 2 of this form. **Send** the documentation outlined on the Self-Employment/Rental Income Worksheet.

Line 3 **Unemployment compensation, strike benefits**

Fill in the total dollar amount of any unemployment compensation or strike benefits received. For unemployment compensation, **send** copies of the initial determination from Employment Security verifying the gross benefit amount; Employment Security check stubs for the full 30 days; or any combination of Employment Security income and documentation from all other sources. For strike benefits, **send** copies of check stubs showing the dates paid and the gross amounts or a signed, dated statement from your union organization with the gross amount paid.

Line 4 **Social Security benefits**

Fill in the total dollar amount of any Social Security benefits received. **Send** a copy of the award letter for the current year's benefits (the benefits statement received at the beginning of the year).

Line 5 **Supplemental Security Income (SSI)**

Fill in the total dollar amount of any Supplemental Security Income (SSI) received. **Send** a copy of the award letter for the current year's benefits (the benefits statement received at the beginning of the year).

Line 6 **Retirement, pension, IRA distributions**

Fill in the total dollar amount of any retirement, pension, or IRA distributions received.

- ***Military retirement*** **Send** a copy of the award letter or cost of living allotment statement.
- ***Railroad retirement*** **Send** a copy of the award letter for the current year's/month's benefits.
- ***Private pension*** **Send** a copy of the pay stub or award letter showing current or monthly benefits from any employer plan, IRA, 401k, or other retirement plan.
- ***Government pension*** **Send** a copy of the pay stub or award letter showing current or monthly benefits.

Line 7 **Child support, family support, alimony**

Fill in the total dollar amount of any child support, family support, or alimony received. Do not include payments from the DSHS adoption support program. **Send** copies of checks or court documents indicating awarded amount; or your statement from the Office of Support Enforcement (of the Department of Social and Health Services).

Line 8 **Insurance benefits**

Fill in the total dollar amount of any insurance benefits received (for example, life insurance payments). **Send** a copy of the award letter or court documents showing the schedule of payments.

Line 9 **Income from interest, dividends, trust, annuity**

Fill in the total dollar amount of any interest, dividends, trust, or annuity income. **Send** copies of statements showing monthly or quarterly amounts/earnings from the institution or investment firm or legal trust documents if income is received from a trust.

Line 10 **Veteran's benefits, military allotment**

Fill in the total dollar amount of any veteran's benefits or military allotments received. For veteran's benefits, **send** a copy of the award letter showing current gross monthly benefits. For military allotments, **send** a copy of the Leave and Earnings Statement.

Line 11 **Labor & Industries benefits**

Fill in the total dollar amount of any benefits received from the Department of Labor & Industries. For workers' compensation, **send** a copy of the award letter showing current gross monthly benefits.

Line 12 **Public assistance (DSHS grants)**

Fill in the total dollar amount of any public assistance, including Department of Social and Health Services grants. **Send** a copy of the award letter showing monthly benefits and the dates received.

Line 13 **Other income**

Fill in the total dollar amount of any other income, including royalties, estate income, or gambling/lottery winnings. For royalties, **send** a copy of the contract and the checks received. For estate income, **send** a copy of the court document(s) showing the income amount. For gambling/lottery winnings, **send** a copy of the check(s) received or your award statement.

Line 14 **Subtotals**

Add all the figures in each individual column (A, B, and C) for your column subtotals.

Line 15 **Total**

Add the subtotals in columns A, B, and C for your total income.

Line 16 **Subtract work-related child care expenses**

Fill in the total amount you paid for care for children who are 12 years old or younger, for the last 30 days or most recent calendar month (limited to $650 per month per dependent). **Send** a copy of any receipts, canceled checks, or credit card invoices for child care expenses, or **send** a copy of the Child Support Order indicating the amount of child support designated for child care expenses and a copy of the canceled checks for child support. Fill in this amount on line 16.

Line 17 **Total gross monthly income**

Subtract line 16 from line 15 for your total gross monthly income.

General Instructions for Self-Employment/Rental Income Worksheet

Fill out the form on the back side of the Monthly Income Worksheet to report any self-employment or rental income. For each line, please enter the appropriate dollar amount or zero ($0) if you have nothing to report. The Self-Employment/Rental Income Worksheet uses income and expense categories that are based on Internal Revenue Service (IRS) Form 1040, Schedules C, E, and F.

- Twelve (12) months of income and expense history are required to determine average monthly profit (or loss). If you have owned the business or rental property for a shorter period of time, please attach a written statement which indicates how long you have owned the business or rental property. Then report current monthly income and expense information for the actual number of months in the worksheet.
- You must use the income and expense information from your most recently filed IRS 1040 form, along with Schedule C (self-employment income), Schedule E (rental income), and/or Schedule F (farm income) to satisfy the 12-month income and expenses history requirement, unless you were not required to file a tax return.
- If you were not required to file a tax return or do not have a copy of your tax return for the most recent year, you must send a transcript of your account, which you can request directly from the IRS by calling 1-800-829-1040.
- Your current net profit (or loss) may have changed since the amount reported in your IRS 1040 form. If so, you may submit updated income and expense documentation (e.g., quarterly tax statements, monthly year-to-date profit/loss statements).
  - Income history from the *previous* tax year must be based on your IRS 1040 form (if filing was required) or on historical monthly income and expense documentation.
  - Income history for the *current* tax year must be based on current income and expense documentation.
- **All expenses must be related to your business or your rental property.** Expenditures that are not business or rental property related cannot be deducted from your gross income as expenses.

Line-by-Line Instructions for Self-Employment/Rental Income Worksheet

Line 1 **Self-employment income or rental income**
Check the box next to the type of income you are reporting. To report income for more than one type of business or rental, please use separate forms.

Line 2 **Business name**
Write in your name or the name of your business.

Line 3 **UBI number**
Fill in your Unified Business Identifier (UBI) number, assigned by the Washington State License Service.

Line 4 **Business address**
Fill in the address of your business. If your business is operated from your home, list your residential address.

Line 5 **Type of business**
Include a description of the type of business. For example: "gas station."

Line 6 **Taxpayer I.D. or Social Security number**
Fill in your Federal Taxpayer I.D. number. Your taxpayer I.D. number is generally your Social Security number, unless your business is a partnership or a corporation.

Business Expense Worksheet

Column I **Twelve-month total**
Fill in the 12-month total (from your most recently filed IRS Form 1040) for the income and expense categories listed in lines 7-27. If you have owned the business or rental property for a shorter period of time, please report financial information for the actual number of months.

Column II **Average monthly expenses**
For lines 8-27, divide the 12-month total from Column I by 12 to get the average monthly expense. Fill in the average. If you have entered a shorter period in Column I, please divide the total by that number of months.

Column III **Average monthly income**
In Column III, box A, please fill in your average monthly income. For box C, see instructions for line 29 under "Calculations," on page 12.

Line 7 **Income: Gross receipts, sales, or rental income**
Fill in the gross income receipts or sales for your business or rental income before any deductions.

Line 8 **Expenses: Merchandise and materials**
Fill in the costs of goods sold, including the purchase price of raw materials, shipping, and storage.

Line 9 **Gross wages paid to employees**
Do not include payments to yourself, your spouse, or partner(s).

Line 10 **Employer's payroll-related taxes**

Include OASI (Social Security), Medicare, L&I (workers' compensation), and UI (Unemployment Insurance) taxes and charges.

Line 11 **Advertising/other promotional expenses**

Fill in your total business or rental advertising, or other promotional expenses.

Line 12 **Car and truck expenses**

Fill in your total car or truck expenses for business-related travel. You may include the actual expense if you have documentation to support the indicated amount, or you may include the standard mileage rate (31 cents per mile for 1999).

Line 13 **Commissions/management fees**

Fill in your total business or rental commissions, or management fees paid to others.

Line 14 **Depreciation**

Fill in your annual business or rental depreciation/amortization amount. If you were not required to file an IRS 1040 form, estimate the number of years the equipment/building will be useful. Divide the purchase price by this number of years to determine annual depreciation.

Line 15 **Insurance**

Fill in only the costs of insurance directly related to the business or rental activity, such as liability and property insurance. Do not include vehicle insurance costs separately if the standard mileage allowance is used for car and truck expenses (see line 12).

Line 16 **Interest — mortgage**

Fill in the interest paid on mortgages on real property used for your business. *Do not* include amounts paid as repayment of principal. If you only use part of your home (or other property) for business, you must determine the "business percentage" of these expenses. Generally, the business percentage for mortgage interest is the same as the percentage of the property used for business (see line 20).

Line 17 **Interest — other**

Fill in the interest paid on business-related loans *other than* mortgages. *Do not* include amounts paid as repayment of principal.

Line 18 **Legal and professional services**

Fill in your total business- or rental-related legal and professional expenses, such as attorney, accountant, and appraiser fees.

Line 19 **Rent or lease — vehicles, machinery, equipment**

Fill in your business- or rental-related expenses for rent or lease of vehicles, machinery, or equipment.

Line 20 **Rent or lease — other business property**

Fill in the business- or rental-related expenses for rent or lease of other business property. If the entire property is not used exclusively for business, you must determine these expenses by finding the "business percentage" of your rented or leased property. You can do this by dividing the area used for business by the total area of the property, including the basement. Measure the area in square feet. Divide the number of square feet of space used exclusively for business by the total number of square feet in the property. For example: Your property measures 1,200 square feet. You use one room that measures 240 square feet for business. Therefore, you use one-fifth (240 ÷ 1,200), or 20%, of the total area for business.

Line 21 **Repairs and maintenance**

Fill in the business- or rental-related expenses for routine repair and maintenance of your business, equipment, vehicle(s), or rental property. *Do not* include payments for your own labor. *Do not* include auto- and truck-related expenses from line 12.

Line 22 **Supplies**

Fill in your business- or rental-related expenses for supplies. You may include expenses for the cost of your office supplies, postage, shipping, and handling for your business.

Line 23 **Taxes**

Fill in your business- or rental-related *non*-payroll taxes, such as property taxes, business and occupational taxes, and business-related license fees.

Line 24 **Travel**

Fill in the cost of business-related travel expenses. Travel expenses include ordinary and necessary expenses incurred while traveling for your business or profession. *Do not* include expenses listed in line 12.

Line 25 **Meals and entertainment**
Fill in the cost of business-related expenses for meals and entertainment.

Line 26 **Utilities**
Fill in the cost of business-related expenses for utilities such as heat, lights, power, and telephone service. Only list those utility expenses used to support your business. If you only use part of your home (or other property) for business, you must determine the "business percentage" of these expenses. Generally, the business percentage for utilities is the same as the percentage of the property used for business (see line 20). For example: Your electric bill is $400 for lighting, cooking, laundry, and television. Only the lighting bill is used for business. If $250 of your electric bill is for lighting and you use 10% of your property for business, then $25 is considered a business-related expense.

Line 27 **Other expenses**
Fill in related expenses for your business or rental unit. Only include "other" expenses that were filed with your tax return. *These expenses must be business-related. Include a description of the expenses in the space provided.*

Calculations

Line 28 **Total average monthly expenses**
Add the figures in Column II, lines 8 through 27, to determine your total expenses. Write this amount in box B.

Line 29 **Average monthly self-employment profit (or loss)**
Subtract the amount in box B from the amount in box A to determine your average monthly self-employment profit (or loss) amount. Write this amount in box C.

Line 30 **Your share of profit (or loss)**
Check the box next to the appropriate form of business. Determine the percentage of business that you own (for example: 70%) and write that percentage in box D. If you and your spouse are both partners in the business, please reflect the sum of your ownership percentages. Use 100% for a sole proprietorship.

Line 31 **Your share of average monthly self-employment/rental net profit (or loss)**
Multiply the amount in box C by the percentage in box D to determine your share of the "average monthly self-employment/rental net profit (or loss)." Write this amount on line 31. *(If you are filling out an application for Basic Health coverage, transfer this amount to the Monthly Income Worksheet, under "Self-employment profit or loss" on line 2.)*

Line 32 Print your name and fill in your Subscriber I.D. number (usually your Social Security number).

Line 33 Sign and date the form in the space provided.

When the Form is Completed

If you are required to submit current income information, including IRS documentation —
The following items must be submitted with your *Family Changes Form*:
- The Basic Health income worksheets (Monthly Income Worksheet and Self-Employment/Rental Income Worksheet, as necessary);
- Proof of all sources of income for the last 30 days (see instructions on the income worksheets for specific documentation requirements); and
- A signed copy of your most recent federal income tax return (IRS Form 1040 and applicable schedules).

If you are required to submit proof of residency —
Your proof of residency must be current, showing your name, residential address, city, and ZIP Code in Washington State, and must be in the form of a copy of one of the following:
- Rent receipt/lease agreement/mortgage contract
- Driver's license/Washington State identification card
- Document showing current receipt of public assistance
- Motor vehicle registration
- Utility bill or property tax notice
- School registration
- Voter registration card
- Pay check stubs or other documentation with the required information

If you live with a friend or relative and **cannot** provide any of the documents listed above, enclose a copy of one of the above documents for the person you live with, along with a dated statement signed by that person, indicating that you live at that address. If you do not have a physical address and you **cannot** provide any of the documentation listed, enclose a signed and dated statement that explains why you are unable to provide this documentation, including a description of where you live and a mailing address where you can receive notices and premium statements. (Basic Health may contact you for further information or documentation, which may cause a delay in processing your application.)